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Supreme Court of the United States

OCTOBER TERM, 1996

DENNIS C. VACCO, Attorney General of the State of New York;
GEORGE E. PATAKI, Governor of the State of New York; and
ROBERT M. MORGENTHAU, District Attorney of New York County,

Petitioners,

v.

TIMOTHY E. QUILL, M.D.; SAMUEL C. KLAGSBRUN, M.D.;
and HOWARD A. GROSSMAN, M.D.,

Respondents.

STATE OF WASHINGTON; CHRISTINE O. GREGOIRE,
Attorney General of Washington,

Petitioners,

v.

HAROLD GLUCKSBERG, M.D., ABIGAIL HALPERIN, M.D.,
THOMAS A. PRESTON, M.D., AND PETER SHALIT, M.D., Ph.D.,

Respondents.

On Writs Of Certiorari To The
United States Courts Of Appeals
and for the Second Circuit and
for the Ninth Circuit

**BRIEF OF THE COALITION OF HOSPICE
PROFESSIONALS AS AMICUS CURIAE FOR
AFFIRMANCE OF THE JUDGMENTS BELOW**

GERALD A. ROSENBERG*
FRANCES KULKA BROWNE
STACEY B. CREEM
J. MARK YOUNG
ROSENMAN & COLIN LLP
975 Madison Avenue
New York, New York 10022
(212) 940-3890

* Counsel of Record

Counsel for Amicus Curiae

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INTEREST OF THE *AMICUS CURIAE*

Amicus curiae, a coalition of medical professionals who have extensive experience in providing hospice and palliative care to terminally-ill patients (the "Coalition") respectfully submits this brief in support of the Respondents.¹ All parties have consented to the filing of this brief, and the letters so stating have been filed with the Court.

Hospice and palliative care professionals participate in a system of care which employs an interdisciplinary team of physicians, nurses, home health aides, ethicists, chaplains, and bereavement counselors providing physical, emotional and spiritual support to people at the end of life. Hospice care does not involve medical interventions intended to defer death. Rather, the professionals, patients and their families treat death as an accepted part of life's continuum, and they work together to lend comfort, dignity and meaning to this final stage. In serving patients' goals and enhancing patients' ability to direct their lives, a principal role for the Coalition's members is providing relief from suffering. For many terminally-ill patients, suffering encompasses debilitating physical distress and psychological agony arising out of the loss of self-defined dignity, and living in conflict with spiritual and philosophical beliefs.

The Coalition believes that physician-assisted suicide must be an option of last resort and then only at the request of the terminally-ill patient. However, terminal illness alone does not justify choosing to hasten death. Aggressive hospice and palliative care -- also known as comfort care -- is highly effective for many patients. The medical profession and policymakers should enhance the availability of comfort care and establish it as

¹ Appended to this brief is a list of the Coalition's members including their credentials and professional affiliations. The members of the Coalition speak from their collective personal experiences in the daily care of severely-ill and terminally-ill patients and do not speak for the institutions with which they are affiliated.

the standard of care for dying patients. However, hospice and palliative care does not always relieve suffering. For some patients, the pain can be so overwhelming that they cannot focus on anything beyond their unremitting suffering, and "life" becomes nothing more than their pain. Other patients appear to attain relief only with sedation so heavy that they cannot function, cannot interact with anyone, and "life" consists merely of lying inert, a condition that those patients reject as intolerable. The Coalition's members have treated patients whose distressing physical symptoms were too severe to be managed and have observed such patients wishing to hasten death. The Coalition believes that those desires can be fully competent and rational choices.

The legal availability of physician-assisted suicide in no way displaces the primacy and effectiveness of hospice and palliative care. As professionals, the Coalition's members intend to continue to respect the wishes of terminally-ill patients and to provide the best palliative care to each of them, including those who might choose a hastened death. Hospice and palliative care providers are particularly expert in determining whether a patient has explored all appropriate palliative treatments and whether the patient requests hastened death because of inadequate efforts to relieve suffering. Indeed, removing legal bans on suicide assistance will enhance the opportunity for advanced hospice care for all patients because regulation of physician-assisted suicide would mandate that all palliative measures be exhausted as a condition precedent to assisted suicide.

The Coalition attends to the physical, emotional and spiritual needs of terminally-ill patients and their families on a daily basis, and therefore is highly qualified to advocate on their behalf. As distinguished professionals in the fields of hospice and palliative care, the Coalition's members have a vital interest in presenting their terminally-ill patients with the broadest range of medical

options to alleviate suffering and promote dignified and meaningful living. These options must include, as a last resort for patients who judge their own suffering unendurable, prescribing medication that will enable those patients to hasten their own imminent deaths. These essential goals will be seriously undermined if this Court reverses the decisions of the Courts of Appeal for the Second and Ninth Circuits.

INTRODUCTION AND SUMMARY OF ARGUMENT

Both the Second and Ninth Circuits have struck down statutes that made it a crime to assist a person in committing suicide, as applied to physician-assisted suicide.² While the Second and Ninth Circuits adopted differing jurisprudential frameworks in reaching their conclusions, both courts examined, analyzed and balanced the respective interests of the individual and the State, but ultimately were not persuaded by the legitimacy and/or weight of the State's proffered justifications for the statutes. See *Quill v. Vacco*, 80 F.3d 716 (2d Cir. 1996) (holding that a New York statute criminalizing suicide

² The terms "physician-assisted suicide," "assisted suicide," and "assisted death" are used interchangeably to refer to the practice in which a physician prescribes a lethal drug but the drug is actually administered by the terminally-ill patient. See *Compassion In Dying v. Washington*, 79 F.3d 790, 802 n.15 (9th Cir. 1996). Terms such as "physician-aid-in dying" or "euthanasia" refer to other medical actions which proximately bring about the death of a patient. Physician-assisted suicide -- as narrowly defined -- is the only practice at issue in this appeal, and the only practice about which the Coalition takes a position in this brief. Despite the adoption of this terminology for the purpose of this brief, the Coalition agrees with the Ninth Circuit that the phrase "physician-assisted suicide" is neither correct nor proper because the cause of death for the patient who seeks to hasten death is the underlying disease. *Id.* at 802. Indeed, it has been noted that, for the terminally-ill, "the choice is not between life and death, but choosing whether to die now or to die later." Jeremy A. Sitcoff, *Death With Dignity*, 29 J. Marshall L. Rev. 677, 680 (1996).

assistance violated the Equal Protection clause of the Fourteenth Amendment); *Compassion In Dying*, 79 F.3d 790 (holding that a Washington statute criminalizing suicide assistance violated the Due Process clause of the Fourteenth Amendment).

The Coalition defers to the Respondents to suggest a correct standard to be applied on these appeals and will not restate their arguments as to the proper mode of analysis. Rather, the Coalition will marshal and discuss empirical evidence of the circumstances surrounding the end of life that is relevant to the resolution of important issues raised by these appeals irrespective of which Constitutional constraints are applicable.

First, the experience of the Coalition's members makes clear, and the medical evidence confirms, that there are some terminally-ill patients whose suffering simply cannot be relieved, even with the best medical care (including terminal sedation).³ For such patients, the ability to control the time and manner of death is an extremely important and highly personal matter. Accordingly, in assessing the individual's interests, the Court must recognize the limits of what palliative care can achieve and thus, the strong interests of such patients in relieving unendurable suffering.

Second, the observations of the Coalition's members reinforce their firmly held belief that criminalizing physician-assisted suicide does not serve the State's interests in: promoting life generally; preventing

³ Terminal sedation refers to a medically-accepted treatment for terminally-ill patients whose suffering cannot be relieved by other means whereby intravenous drugs (usually barbiturates or benzodiazepines) are administered to induce a pharmacologic coma. Despite some imprecision in the empirical evidence, it has been estimated that between 5% and 52% of dying patients entering home palliative care units have been terminally sedated. Paul Rousseau, *Terminal Sedation In The Care Of Dying Patients*, 156 Archives Internal Med. 1785 (1996).

abuse, mistake and coercion in decisions to hasten death; preserving the integrity of the medical profession; and protecting the dying individual's loved ones. Assisted suicide occurs despite state laws. Were physician-assisted suicide legal, appropriate procedural safeguards could be enacted to ensure that the individual has explored all appropriate palliative care options and is not choosing a hastened death as a result of inadequate efforts to relieve pain and suffering, or any untoward influence. In assessing the legitimacy and/or weight of the States' interests, the Court should consider the experience of palliative care experts and the medical evidence set forth herein which demonstrates that the States' interests are not undermined by permitting physician-assisted suicide.

ARGUMENT

STATUTES THAT PREVENT THE TERMINALLY-ILL FROM OBTAINING MEDICAL ASSISTANCE TO HASTEN DEATH AND END SUFFERING ARE UNCONSTITUTIONAL

As shown below, someone who is suffering grievously on his or her deathbed has a powerful interest in accelerating the time of death. Conversely, the States' proffered interests are furthered by legalizing physician-assisted suicide. Accordingly, the judgments below should be affirmed.

A. Terminally-Ill Patients Have A Powerful Interest In The Legal Ability To Hasten Imminent Death, Relieve Unendurable Suffering And Maintain Their Dignity In The Final Days Of Their Lives.

Hospice professionals are committed to the tenet that patients facing imminent death should be treated compassionately and that they should be able "to make as many choices as possible for themselves -- both in living what is left of life and in dealing with fatal illness."

National Hospice Organization ("NHO") *Amicus Br.* at 3. Accordingly, hospice professionals -- including the NHO -- believe that a terminally-ill patient is entitled to the best palliative care available but is also entitled to the legal option of refusing any medical intervention, including the provision of artificially-supplied hydration and nutrition. *See Id.*; *Cruzan v. Director, Missouri Dep't of Health*, 497 U.S. 261 (1990). The personal decision of a terminally-ill and suffering individual to hasten death with medical assistance is entirely consistent with hospice philosophy that respects patient autonomy and promotes compassionate treatment. Physician-assisted suicide should be permitted in the rare cases where medical treatments (including terminal sedation and pharmacologically-induced coma) cannot eliminate a dying individual's pain and suffering or are not desired by the patient. Thus, physician-assisted suicide is a compassionate response to an individual's powerful interest in controlling the time and manner of his or her death.

1. All Pain And Suffering Cannot Be Relieved For All Terminally-Ill Patients -- In its medical experience, the Coalition has encountered dying patients whose suffering and misery cannot be relieved with the most aggressive palliative measures. In the face of diseases which destroy the body and rob the spirit, such patients have a powerful interest in obtaining medical assistance to hasten their imminent death.

Hospice professionals know that hospice care can relieve or lessen the physical pain of most terminally-ill patients and that hospices generally provide better palliative care than do non-hospice treatment programs. *See, e.g.,* Jamie H. Von Roenn, *Physician Attitudes and Practice in Cancer Pain Management*, 119 *Annals Internal Med.* 121 (1993) (reporting that 90% of cancer patients in hospice units report pain relief, whereas 50% to 80% of cancer patients do not have adequate pain control outside

the hospice environment). Nevertheless, all hospice professionals, including the NHO, now acknowledge that irrespective of the efficacy of palliative medicine, there are some patients whose physical pain cannot be relieved adequately. *See NHO Amicus Br.* at 8; Howard Brody, *Assisted Death: A Compassionate Response to a Medical Failure*, 327 *New Eng. J. Med.* 1384, 1385 (1992) ("[I]n a small percentage of cases palliative efforts will fail"); Larry Beresford, *Hospice and the End of Life Debate*, 9 *Cal. Hospice Rep.* (Summer 1991), at 8 ("Everybody who has worked in hospice for very long knows a handful of cases where the patient's suffering was simply untreatable.").

Hospice professionals also know, and the Second and Ninth Circuits have recognized, that the suffering of the terminally-ill is not merely physical. *See Quill*, 80 F.3d at 729-30; *Compassion In Dying*, 79 F.3d at 812. The mental anguish and personal degradation that precedes death are often more severe than the physical pain. Patients may experience suffering associated with mechanical life-sustaining apparatuses, loss of control over bodily functions, and inability to care for themselves and to participate fully in life activities. In spite of the best palliative care, the prolonged physical deterioration and decay of body, skin, bowels and mind can lead to the reality of existence as a living carcass that can become repugnant to the most caring and stalwart of families, and to the lingering patients themselves. For these patients

[r]elinquishing control and independence, or compromising personal standards of behavior and "quality of life," may be experienced as worse than death. Ironically, accelerating death becomes a way to preserve the self.

Susan D. Block & J. Andrew Billings, *Patient Requests To Hasten Death*, 154 *Archives Internal Med.* 2039, 2043 (1994).

Likewise, one nurse practicing home hospice care has described the nature of terminal suffering as follows:

For many, the pivotal issue is quality of life. Although free of pain, they hate living with the spinal cord compression that left them incontinent of bowel and bladder. Or they hate the inhuman substance that pours from their tumor and onto their clothes, into their hair, onto their furniture. They would rather be dead than live with the brain tumor that has locked them inside a motionless, aphasic body. Like most hospice nurses, my cache of horror stories is endless.

Theresa M. Stephany, *Hospice-Assisted Suicide*, 11 Home Healthcare Nurse 50 (1993). For such patients, accelerating the dying process is the only available relief from suffering that medical professionals can provide.

In addition, terminally-ill patients may have religious or spiritual convictions that render their suffering even more difficult to bear. See, e.g., Timothy E. Quill, *A Midwife Through The Dying Process* (The Johns Hopkins University Press 1996) at 14 ("In Zen Buddhism, how one dies has considerable bearing on how one is reborn in the next life. Being at peace is the best one can hope for and dying in agony puts one at risk.").

As death becomes more imminent, pain and suffering become progressively more difficult to treat. See Nathan I. Cherny & Russell K. Portenoy, *Sedation in the Management of Refractory Symptoms*, 10 J. Palliative Care 31 (1994). For example, terminal agitation (which is also known as terminal restlessness) is a well-documented and heart-wrenching condition that precedes death for many patients, particularly those afflicted with cancer. See generally Ian N. Back, *Terminal Restlessness in Patients with Advanced Malignant Disease*, 6 Palliative Med. 293 (1992). Patients suffering from terminal agitation are generally unable to remain still and exhibit motor restlessness such as involuntary muscle twitching or volitional tossing and turning. Terminally agitated patients are also worried, uneasy or anxious. *Id.* This is a particularly distressing

condition for the patient to bear and for his or her loved ones to witness.

In concluding that, in some limited situations, physician-assisted suicide may be the "least terrible of a set of difficult alternatives," hospice professionals have acknowledged the powerful roles that physical distress and the loss of dignity and personal autonomy play in creating an intolerable state of suffering that no medical treatment will alleviate. Block *et al.*, 154 Archives Internal Med. at 2045. For some patients, such intense suffering is unbearable and leaves them no option but to request medical assistance in hastening their inevitable deaths. See Anthony L. Back *et al.*, *Physician-Assisted Suicide and Euthanasia in Washington State*, 275 JAMA 919, 924 (1996) ("Patients who request [physician-assisted suicide] . . . are worried about losing control, being a burden, being dependent, and losing dignity."); Clive Seale & Julia Addington-Hall, *Euthanasia: Why People Want To Die Earlier*, 39 Soc. Sci. & Med. 647 (1994) (reporting that requests for suicide rise as levels of distress and dependency increase); Robert J. Blendon *et al.*, *Should Physicians Aid Their Patients In Dying?* 267 JAMA 2658 (1992) (reporting that not wishing to be dependent upon machines and not wanting to continue living unable to perform most daily activities are reasons frequently cited by terminal patients for hastening death).

Numerous public opinion surveys demonstrate that the majority of Americans favor respecting autonomous decisions by terminally-ill patients to control the manner and circumstances of their death, and support legalization of physician-assisted suicide. *Compassion In Dying*, 79 F.3d at 810 (citing survey data). See also *Knowledge and Attitudes Related to Hospice Care* (Gallup Poll Commissioned by the NHO (1996)). Individuals are particularly likely to favor physician-assisted suicide when they are afflicted with a debilitating and terminal disease. See Brett Tindall *et al.*, *Attitudes to Euthanasia and*

Assisted Suicide in a Group of Homosexual Men with Advanced HIV Disease, 6 J. Acquired Immune Deficiency Syndromes 1069 (1993) (reporting that "a large proportion of subjects with severe HIV disease in this sample wanted to have the option of euthanasia available should they become severely ill"). Accordingly, the beliefs of the American people are consistent with the experience of the Coalition in dealing with terminal patients on a daily basis, which in turn lead to the inescapable conclusion that dying individuals have a powerful interest in controlling the timing and manner of their death.⁴

2. Terminal Sedation (Pharmacologically-Induced Coma) Does Not Obviate The Choice Of Physician-Assisted Suicide For Those Who Face Imminent Death. -- Opponents of physician-assisted suicide erroneously argue that terminal sedation by use of barbiturates or benzodiazepine to induce unconsciousness obviates the need for assisted suicide. See, e.g., Am. Geriatrics Soc'y *Amicus* Br. at 25. The fact is that terminal sedation has not been proven to eliminate either the pain, suffering or distress of dying patients. Moreover, many patients and the family members who are caring for them at home find the reality of the patient's lingering for days to weeks in a medically-induced comatose state to be antithetical to a good and dignified death. Finally, and ironically, the fact that terminal sedation is practiced by some medical professionals undermines arguments against physician-assisted suicide inasmuch as the practice may also have the "double effect" of hastening death.

Medical professionals have agreed that terminal sedation may be used with the intent to: (1) relieve physical pain; (2) produce an unconscious state before the

⁴ The fact that state legislatures have not repealed ancient statutory prohibitions against physician-assisted suicide is only the weakest kind of contrary evidence of public will, especially where such statutes have gone unenforced for generations.

withdrawal of artificial life support; or (3) relieve non-physical suffering. Robert D. Truog *et al.*, *Barbiturates in the Care of the Terminally-ill*, 327 New Eng. J. Med. 1678 (1992). Terminal restlessness, for example, is commonly treated by putting the patient into a pharmacologic coma. Generally, nutrition and hydration are also discontinued when the patient is under sedation, and the patient then dies of starvation and/or dehydration. Physicians recommend such treatment to dying patients and their families on the grounds that the sedated state will relieve the individual's suffering and enable him or her to die peacefully and "naturally."

Unfortunately, while a terminally-sedated patient exhibits an outwardly peaceful appearance, medical science cannot verify that the individual ceases to experience pain and suffering. To the contrary, studies of individuals who have been anaesthetized (with the same kinds of drugs used in terminal sedation) for surgery (and who are in a deeper comatose state than terminally-sedated patients since their breathing must be sustained by a respirator) have demonstrated that painful stimuli applied to the patient will cause a significant increase in brain activity, even though there is no external physical response. See, e.g., Orlando R. Hung *et al.*, *Thiopental Pharmacodynamics: Quantitation of Clinical and Electroencephalographic Depth of Anesthesia*, 77 *Anesthesiology* 237 (1992).

Other studies have established that anesthetized patients may continue to perceive and remember events that occur around them despite appearing "unconscious" to others. See, e.g., R.C. Cork *et al.*, *Is There Implicit Memory After Propofol Sedation?* 76 *British J. Anesthesiology* 492 (1996). Thus, terminally-sedated patients may continue to suffer pain and be aware of their dying condition without being able to communicate their suffering and fears. One can hardly imagine a more distressing and dehumanizing way to die.

Even assuming *arguendo* that terminal sedation could be proven to relieve physical pain and eliminate awareness of death, the treatment is repugnant to many patients who do not wish to prolong the inevitable by lingering in a comatose state. The experience of a terminally-ill cancer patient, Renee Sahm, graphically illustrates the concerns of patients who reject terminal sedation:

A week later [after Renee's discharge from a hospice unit], Renee's hallucinations and panic set in. Scorpions crawled about her room; over and over, she shouted in fear during an imagined plane crash. Renee tossed violently about in her bed while friends and her attendant provided a twenty-four hour watch -- knowing that the only alternative to the hallucinations would be heavy pharmacologic sedation. But while Renee had still been coherent, she'd spoken adamantly against this very sedation. Her friends agreed: Since she was slipping in and out of periods of coherence, heavy sedation might deprive Renee of important final lucid moments.

Lonny Shavelson, *A Chosen Death*, (Simon & Schuster 1995) at 211.

There are many other valid reasons for rejecting terminal sedation as a sufficient substitute in all cases for physician-assisted suicide. Some patients refuse terminal sedation because of the burden it places on their loved ones, who are often called upon to witness the disintegration of their family member or friend by caring for the comatose body until death. Such care may include frequent turning, care of odorous bed sores, and management of urinary and fecal incontinence. Ironically, a compelling description of the emotional suffering inflicted upon family and friends of terminally-sedated patients comes from a physician who opposes the legalization of physician-assisted suicide:

Family members caring for a dying loved one who is in the throes of dying, perhaps moaning incomprehensibly or breathing noisily, may find themselves suffering in true compassion. And they may be in doubt, guilt, and confusion: wishing for the death of a loved one whom they will miss -- indeed already miss -- and who they wish was either well and back with them or peacefully gone. This is made all the more poignant and intense by the near-universal sleep deprivation that accompanies this experience.

Ira R. Byock, *Consciously Walking the Fine Line: Thoughts on a Hospice Response to Assisted Suicide and Euthanasia*, 9 J. Palliative Care 25, 27 (1993). Despite witnessing such suffering, Dr. Byock nonetheless questions whether physician-assisted suicide is preferable. The Coalition submits that each dying patient -- not the State or the patient's physician -- must answer this question for himself or herself. Respecting the dignity of dying patients means respecting that individual's deeply personal choice about how to live in his or her final days. See *Planned Parenthood v. Casey*, 505 U.S. 833, 851 (1992) ("These matters, involving the most intimate and personal choices a person may make in a lifetime . . . are central to the liberty interest protected by the Fourteenth Amendment.")

It is also significant that terminal sedation is advocated and practiced by the most vehement opponents of physician-assisted suicide even though the patient's death may be hastened. See, e.g., Am. Med. Ass'n *Amici Br.* at 6; Ira R. Byock, *The Euthanasia/Assisted Suicide Debate Matures*, Am. J. Hospice & Palliative Care, Mar./Apr. 1993, at 8, 10. The proffered justification for terminal sedation is based upon the "principle of double effect," whereby medical treatments with the intended effect of relieving pain and suffering are permissible even though a side effect is the hastening of death. Nathan I. Cherny *et ano.*, 10 J. Palliative Care at 36.

The Coalition submits that, as a practical matter, the only distinction between terminal sedation and physician-assisted suicide is that the period of time between administration of the lethal agent and death is condensed in physician-assisted suicide. Ascertaining the "intent" of the physician who advocates terminal sedation is a complicated, if not altogether impossible, task. See Timothy E. Quill, *The Ambiguity of Clinical Intentions*, 329 New Eng. J. Med. 1039 (1993). Indeed, medical professionals know that the practice of terminal sedation is one method of assisting patients in hastening death:

Justification based on the principle of double effect requires that the clinician intend only to relieve the patient's suffering and not to cause death. When barbiturates or opioids are administered to the terminally-ill, however, both effects are often seen as desirable. The hastening of death in these cases is sometimes referred to as "a blessing in disguise." Justification by double effect may therefore function as a "fig leaf" for euthanasia.

Truog *et al.*, 327 New Eng. J. Med. at 1680. See also Franklin G. Miller & Howard Brody, *Professional Integrity and Physician-Assisted Death*, 25 Hastings Ctr. Rep. 8, 12 (1995) ("[I]t is not clear that relieving terminal suffering by inducing unconsciousness, which may hasten death, is morally superior to voluntary physician assisted death.").

The distinction between terminal sedation and physician-assisted suicide further blurs when one considers that the criteria for terminal sedation are similar to those proposed for physician-assisted suicide. Compare Paul Rousseau, *Terminal Sedation in the Care of Dying Patients*, 156 Archives Internal Med. 1785 (1996) (Prior to the initiation of sedation, clinicians must ascertain the need for sedating therapy, including the presence of a terminal disease with impending death, exhaustion of all other palliative treatments, agreement by patient and family members of the need for sedation, and a current do-not-

resuscitate order.) *with infra*, pp. 17-18 (Carefully considered guidelines for physician-assisted suicide recommend that the primary care physician document: a terminal diagnosis; a judgment that the patient is mentally competent and not suffering from depression; that high-quality palliative care and hospice care, psychological care and other treatment have been made available to the patient; and that the patient's decision was freely and independently made, without coercion or financial duress.).

B. The States' Interests Are Furthered
By Permitting Terminally-Ill Individuals
To Exercise This Personal Choice.

The Coalition is convinced that assisted-suicide already exists in fact, far beyond the power of medical professionals, this Court or any legislature to prevent. Many terminally-ill individuals now carry out acts of suicide with the assistance of loved ones. Likewise, there is empirical evidence that medical professionals already assist in acts of suicide cloaked in the sanctity of the physician-patient relationship. Recognizing these unvarnished facts, the question before the Court then, is whether trained medical professionals should be permitted legally to provide a full range of options to terminally-ill patients. For the reasons set forth below, the Coalition submits that medical professionals and terminally-ill patients should be permitted to explore all options for the patient, including the hastening of death, and that this would further the expressed state interests.

1. Physician-Assisted Suicide Now Occurs Secretly Requiring That Appropriate Procedural Safeguards To Protect Terminally-Ill Patients From Coercion And Untoward Influence Be Established. -- Physician-assisted suicide, although presently illegal in most states, is nonetheless a common practice, motivated by the sincere belief of many doctors that it is imperative

for some patients. This practice should be regulated not outlawed.

Surveys demonstrate that there is history of physicians helping their patients to die.⁵ In a blind study of primary care physicians in the State of Washington, 26% of doctors surveyed reported that they had received one or more explicit requests for physician-assisted suicide and/or euthanasia, and 12% of doctors surveyed had received such requests within the last year. Anthony L. Back *et al.*, *Physician-Assisted Suicide and Euthanasia in Washington State*, 275 JAMA 919, 920 (1996). Physicians provided a lethal prescription to 24% (38 of 156) of the patients who requested physician-assisted suicide. *Id.* at 922. See also David J. Doukas *et al.*, *Attitudes and Behaviors on Physician-Assisted Death: A Study of Michigan Oncologists*, 13 J. Clinical Oncology 1055 (1995) (reporting that 40% of responding Michigan oncologists reported patient-initiated requests of both assisted suicide and active euthanasia, 18% reported active participation in assisted suicide and 4% reported participation in euthanasia); L. Slome *et al.*, *Physicians' Attitudes Toward Assisted Suicide in AIDS*, 5 J. Acquired Immune Deficiency Syndrome 712 (1992) (reporting that 23% of responding physicians who treat AIDS patients would likely grant a patient's request for assistance in hastening death). Thus, medical professionals assist in suicide in spite of statutes criminalizing the practice – even in states like Michigan where public scrutiny is heightened by media attention to the practice.

The reality of physician-assisted suicide undercuts the States' argument that their statutes effectively control

the practice. Evidence of substantial defiance of the law, and the obvious conclusion that the States are powerless to prevent it, renders statutes prohibiting assisted suicide merely symbolic, essentially defended as a form of state propaganda of one moralistic view, rather than a realistic regulation of behavior. See *Carey v. Population Services Int'l*, 431 U.S. 678, 715 (1977) (Stevens, J., concurring). The challenge then, is to transform those factual observations into a mandate for constructive governance, upholding the individual's liberty interest in the control of his or her own physical being, while at the same time guarding against irresponsible decisions to undertake suicide.

Carefully considered guidelines for assuring just that result have already been promulgated by medical professionals. For example, in the San Francisco metropolitan area a network of ethics committees promulgated the *BANEC-Generated Guidelines for Comprehensive Care of the Terminally Ill*. Bay Area Network of Ethics Committees, September 1996. Those guidelines provide for safeguards and documenting procedures as part of a high general-care standard for patients with terminal illnesses. The guidelines emphasize that the primary care physician must make an initial referral to a hospice program or to a physician experienced in palliative care. *Id.* at 2. They also recommend that the primary care physician document: (1) a terminal diagnosis; (2) a judgment that the patient is mentally competent and not suffering from depression; (3) that the finest available palliative care and hospice care has been made available to the patient; and (4) that the patient's decision was freely and independently made, without coercion or financial duress. *Id.* at 3. A second, documented opinion from another physician who should have expertise in palliative end-of-life care is also recommended. *Id.* To ensure that the decision was voluntary, the patient must execute a written consent form

⁵ Establishing empirical evidence of physician-assisted suicide is impeded by the fact that the practice is illegal in most states. Accordingly, researchers have been forced to conduct blind surveys of physicians, since an open admission could subject the respondent to the risk of criminal prosecution.

twice, with a two-day waiting period between signatures. *Id.* at 3-5. Finally, the guidelines provide for a state registry of all documented cases of assisted suicide. *Id.* Similar careful standards and safeguards have been developed in the States of Michigan and Oregon. Michigan Commission On Death and Dying, *Final Report*, (June 1994) (appending a Michigan Model Statute Supporting Aid-In-Dying); Or. Rev. Stat. § 127.800 (1995) (describing procedural safeguards in Oregon's Death With Dignity Act). See also Sitcoff, 29 J. Marshall L. Rev. 677; Charles H. Baron *et al.*, *A Model State Act to Authorize & Regulate Physician-Assisted Suicide*, 33 Harv. J. on Legis. 1 (1996); Franklin G. Miller *et al.*, *Regulating Physician-Assisted Death*, 331 New Eng. J. Med. 119 (1994); Timothy E. Quill *et al.*, *Care of the Hopelessly Ill: Proposed Clinical Criteria for Physician-Assisted Suicide*, 327 New Eng. J. Med. 1380 (1992).

Such guidelines, which would properly be enacted by state legislatures, are necessary because, *inter alia*, they minimize the possibility of physician-assisted suicide for those patients who are depressed such that they lack the mental competency to decide whether to accelerate their death. Although depression can be a major factor in an individual's decision to end his or her life and can in some instances impair competency, empirical studies demonstrate that not all patients who express an interest in physician-assisted suicide suffer from depression that impairs competency. William Breitbart *et al.*, *Interest In Physician-Assisted Suicide Among Ambulatory HIV-Infected Patients*, 153 Am. J. Psychiatry 238, 241 (1996). ("[O]ur data also suggest . . . that not all of patients' interest in physician-assisted suicide is the result of depression."). Palliative care professionals, including psychiatrists, know that it is normal for a terminally-ill and suffering individual to be unhappy, but these professionals have the skill and experience to distinguish between patients who

can make rational and competent decisions and those who cannot.

Moreover, the proposed guidelines would also limit physician-assisted suicide to the terminally-ill. Although some briefs submitted to the Court have raised doubts as to the ability of the medical profession to estimate the life expectancy of their patients, physicians and hospice professionals in fact routinely make just such terminal diagnoses. Indeed, the threshold criterion for enrollment of hospice patients into the federal Medicare and state Medicaid benefit programs is a prognosis of six months or less. 42 U.S.C.A. §§ 1395(d)(d), 1395(f)(i), 1395(x)(dd)(3)(A) (West Supp. 1996); 42 C.F.R. §§ 418.22, 418.200 (1996); see also *NHO Medical Guidelines For Determining Prognosis In Selected Non-Cancer Diseases*, at 2-3 (1995) (parameters used to determine whether a patient is appropriate for hospice care and eligible for Medicare/Medicaid Hospice Benefit, based on terminal condition).⁶ Accordingly, the suggestion that terminal diagnoses are impossible is simply incorrect and flies in the face of routine medical prognostication.

The Coalition submits that the proposed guidelines, which should be enacted by state legislatures, are sufficient to prevent abuse, coercion or improper decision-making. This is due in part to the nature and philosophy of hospice care, and the resulting relationships between hospice professionals and their patients. The parade of horrors envisioned by opponents of physician-assisted suicide is greatly exaggerated. Under a regulated system, a professional would be required to assess whether such patient was experiencing pain, fear or depression which

⁶ The NHO's newly-issued Second Edition Guidelines offers procedural standards to make the same determination, on roughly the same criteria, but now labels it a "life limiting" rather than a "terminal" condition. See *NHO Medical Guidelines For Determining Prognosis In Selected Non-Cancer Diseases* (2d ed. 1996) at 6-7.

could be alleviated, thereby relegating suicide to an alternative of last resort -- to be used only when all other palliative and psychosocial interventions have been tried and have failed.

2. The Availability Of Physician-Assisted Suicide Promotes The States' Interest In Preserving Life.

-- This Court has acknowledged the States' interest in preserving human life. *See, e.g., Cruzan*, 497 U.S. at 282. The Coalition submits that physician-assisted suicide accords with the principle of promoting life because affording a patient the choice to hasten death, should his or her suffering become intolerable, can sustain and preserve that individual's will to live.

Numerous studies have revealed that a significant reason terminally-ill individuals contemplate suicide is the feared loss of control often associated with the progression of many terminal diseases. *See supra* pp. 9-10. Proscribing physician-assisted suicide enhances this sense of impotence by discouraging dying patients from engaging in meaningful discussions with their doctors about the very thoughts that weigh heavily on their minds. Thus, fears about the tolerability of their final days are internalized, rather than shared with experienced professionals. Saddled with such fears, many patients conclude that the only method of preserving self-determination and human dignity is to take their own lives while they are physically and mentally capable of doing so, long before they are disabled by their disease, and often before all possible palliative options have been fully explored. *See Back et al., Physician-Assisted Suicide and Euthanasia in Washington State: Patient Requests and Physician Responses*, 275 JAMA at 922 (1996); Timothy R. Coté *et al., Risk of Suicide Among Persons With AIDS*, 268 JAMA 2066 (1992); Kay Longcope, *AIDS Related Suicide Up*, Boston Globe, Mar. 17, 1990, at A25.

Allowing doctors to help a mentally competent patient avoid a prolonged and often painful death would

alleviate the some of fear and desperation inherent in a patient's confrontation with his or her imminent mortality. In fact, those doctors who have agreed to assist a patient in ending his or her life have acknowledged that their articulated willingness to provide choice in the face of death gave their patients the security and reassurance to continue to live meaningful lives. For example, Dr. Quill describes his agreement to prescribe barbiturates for a long-time patient and close friend dying of leukemia as follows:

In our discussion, it was apparent that she was having trouble sleeping, but it was also evident that the security of having enough barbiturates available to commit suicide when and if the time came would leave her secure enough to live fully and concentrate on the present. It was clear that she was not despondent and that in fact she was making deep, personal connections with her family and close friends. I made sure that she knew how to use the barbiturates for sleep, and also that she knew the amount needed to commit suicide. We agreed to meet regularly, and she promised to meet with me before taking her life, to ensure that all other avenues had been exhausted. I wrote the prescription with an uneasy feeling about the boundaries I was exploring -- spiritual, legal, professional and personal. Yet I also felt strongly that I was setting her free to get the most out of the time she had left, and to maintain dignity and control on her own terms until her death.

Timothy E. Quill, *Death & Dignity: A Case of Individualized Decision Making*, 324 New Eng. J. Med. 691, 693 (1991). *See also* Betty Rollin, *Last Wish* (Linden Press/Simon & Schuster 1985).

Moreover, many patients who are prescribed lethal medications never actually take them. *Back et al.*, 275 JAMA at 922. And, most of those patients who do use

the drugs to hasten their death do not do so immediately upon receiving them, but rather choose to live longer. *Id.*

The experience of Pierre Nadeau is illustrative on this point. Pierre became deeply depressed when he discovered he was dying of AIDS, and was obsessed with suicide. After his friend Stephen promised that he would help Pierre die if his sickness prevented him from doing it on his own, his depression lifted. When asked whether he would have committed suicide if, at the time he wanted to kill himself, the means had been readily available and legal, Pierre responded, "No Actually, if it was that easy I would wait, because I'd know that I could do it whenever I wanted to." Shavelson, *A Chosen Death* at 54. See also Gina Kolata, *AIDS Patients Seek Solace In Suicide But Many Risk Added Pain In Failure*, N.Y. Times, June 14, 1994, at C1 (reporting that a dying patient who had gathered sufficient lethal drugs but did not use them stated, "Having the means to kill [myself] . . . has diminished my horror, as though I was facing an enemy on a battlefield stark naked and now I have armour.").

In opposing physician-assisted suicide, the States fail to recognize that patients who are denied this personal choice may also be denied the opportunity for positive end-of-life experiences. Such patients may spend their last days worrying about how they are going to hoard enough sleeping pills, or other lethal drugs; hide them from their health care professionals and loved ones until the point when their condition becomes intolerable; and ascertain what method of suicide will end their suffering, rather than intensify it if the attempt fails. A patient may even choose to experience pain in order to create a stash of narcotics to be used later to induce death. The anxiety felt by patients contemplating suicide is enhanced by the knowledge that a botched suicide attempt "may cause [additional] physical suffering, shame, humiliation, and a deepened sense of helplessness." Block *et al.*, 154

Archives Intern Med. at 2040; Quill, 324 New Eng. J. Med. at 693.

The potential for medical assistance in hastening death can actually provide patients with the sense of control and comfort needed to spend their final days meaningfully examining spiritual issues, and strengthening bonds or resolving conflicts with loved ones — precisely the type of positive end-of-life experiences that the States incorrectly argue would be diminished by the availability of physician-assisted suicide.

3. The Availability Of Physician-Assisted Suicide Will Support The Integrity Of The Medical Profession. — The Coalition believes, and the Ninth Circuit has found, that outlawing physician-assisted suicide may diminish the public's trust and respect for the medical profession. *Compassion In Dying*, 79 F.3d at 827. Accordingly, the Coalition submits that each medical professional should be permitted to decide for himself or herself (consistent with appropriate guidelines) whether to assist a terminally-ill patient in accelerating death, and that such assistance is consistent with the proper role of medical professionals in society.

Any evaluation of the integrity of the medical profession must take into account the increasing role that medical technology plays in forcing upon patients what many consider to be unacceptable ways of dying. Howard Brody, *Assisted Death: A Compassionate Response to a Medical Failure*, 327 New Eng. J. Med. 1384 (1992). Indeed, medical technology has exacerbated public fear of death. The public knows that doctors tend to overtreat terminally-ill patients. Steven H. Miles, *Physicians and Their Patients' Suicides*, 271 JAMA 1786 (1994); Kathleen M. Foley, *The Relationship of Pain and Symptom Management to Patient Requests for Physician-Assisted Suicide*, 6 J. Pain & Symptom Mgmt. 289, 290 (1991). Moreover, when modern medicine fails to provide a cure, some doctors withdraw, forcing a terminally-ill patient to

sustain much of the dying process on his or her own. *Id.*; see also Betty Rollin, *Last Wish* (Linden Press/Simon & Shuster 1985). In this context, the number of studies documenting inadequate palliative education and care by doctors and health care professionals is distressing but not surprising. See, e.g., Alfred F. Connors *et al.*, *A Controlled Trial to Improve Care for Seriously Ill Hospitalized Patients*, 274 JAMA 1591 (1995). Thus, the integrity of the medical profession has been called into question because patients fear that physicians will either overtreat them with life-prolonging technology long after a return of meaningful function is impossible, or abandon them when they need control of symptoms or emotional support.

The public's concern over medical disregard for patient autonomy is also supported by empirical evidence. For example, physicians do not always involve their patients in discussions involving life-sustaining treatment. See Terri R. Fried *et al.*, *Limits of Patient Autonomy: Physician Attitudes and Practices Regarding Life-Sustaining Treatments and Euthanasia*, 155 Archives Internal Med. 722, 723 (1993). The public's desire for increased self-determination in end-of-life medical decisions has been expressed through the successful ballot initiative for physician-assisted suicide in Oregon and similar referendums in California and Washington. The remarkable popularity of *Final Exit*, a manual for suicide, also testifies to the widespread public desire for certainty about how to end one's life reliably and painlessly. Block *et al.*, 154 Archives Internal Med. at 2040.⁷

The origins of hospice care are a testament to the medical community's neglect, or inadequate treatment, of

⁷ The availability of information concerning methods of committing suicide does not eliminate the need for legalized assisted-suicide. The hoarded pills and plastic-bag methods advocated in *Final Exit* hardly provide the dignified and certain ending sought by suffering patients. These methods are used in desperation, not dignity.

the terminally-ill. Hospice care developed out of a sense of frustration with the treatment of the dying, and as a reaction against the abuses of an impersonal high-technology approach to patients. Robert J. Miller, 20 *Hospice Care as an Alternative to Euthanasia*, 90 Law Med. & Health Care 127 (1992). Patient autonomy, personal choice and reclaiming control in one's final days of life have always been central to hospice philosophy. See Larry Beresford, *Hospice and the End of Life Debate*, Cal. Hospice Rep., Summer 1991, at 6. Thus, hospice professionals believe that a doctor's involvement in the dying process should be sufficiently flexible to account for all personal choices so that the individual need not experience a death characterized by abandonment, pain, impersonality and degradation. Brody, 327 New Eng. J. Med. at 1385.

Prohibiting physician-assisted suicide for suffering patients also undermines doctors' ability to provide the beneficence and comfort historically required of them. Quill *et al.*, 327 New Eng. J. Med. at 1380. The alleviation of suffering is as much a part of traditional medical care as is the prolongation of life. Helping a terminally-ill patient die at his or her request is at one end of the continuum of lifelong medical care when healing becomes impossible — as it does in every life. Faye J. Girsh, *Physicians Aid in Dying: What Physicians Say, What Patients Say*, 157 W. J. Med. 188, 189 (1992); Block *et al.*, 154 Archives Internal Med. at 2040.

Increasing the role of physicians, hospice and other medical professionals in the process of dying will enhance the public's respect for the medical profession on both an individual and institutional level. Brody, 327 New Eng. J. Med. at 1385 (1992); Franklin G. Miller *et al.*, 331 New Eng. J. Med. at 119 (1994). On an individual level, it will enable doctors and patients to talk about what the end will be like, thereby reinforcing the doctor-patient relationship. Because doctors often have intense

relationships with dying patients, a doctor's refusal to help a patient hasten death "may be experienced by the patient as an abandonment, a rejection or an expression of inappropriate paternalistic authority." Block *et al.*, 154 Archives Internal Med. at 2045. In addition, open communication about what is causing the patient to make such a request will be fostered, and may ultimately lead to improved management of the distressing symptoms. Brody, 327 New Eng. J. Med. 1394. The doctor's role in enabling a patient to choose a good death is vital because patients lack the technical knowledge and skill, acting independently, to end their lives in a certain and humane manner. Those inclined to end their lives will not be prevented from doing so if physician-assisted suicide is illegal; they will instead opt for more grisly and less effective means.

On an institutional level, legalized assisted-suicide will enable physicians to consult with one another about a patient's request to hasten death, which also increases the likelihood that the patient's condition will be fully examined. Back, 275 JAMA at 925; Miller *et al.*, 331 New Eng. J. Med. at 121; Quill *et al.*, 327 New Eng. J. Med. at 1383. Moreover, legalization and regulation will put a clear responsibility on doctors to assess and treat depression and pain, commonly present and insufficiently treated in patients with terminal illnesses. Howard Brody, *Physician-Assisted Suicide Should Be Legalized*, 53 Archives Neurology 1182 (1996). Thus, the need for physician-assisted suicide would be reduced.

The States' argument that physician-assisted suicide undermines the public's respect for the medical profession lacks merit since physicians now engage in many legal practices to accelerate death for their patients. All hospice professionals, including the NHO, agree that physicians may terminate life-support systems, withhold all other forms of medical treatment, and may even administer drugs to sedate with full knowledge of their

"double effect." NHO *Amicus* Br. at 3; Miller *et al.*, 331 New Eng. J. Med. 119. Physicians who prescribe drugs to hasten death will not be looked upon as "killers" any more than physicians who now take actions, such as disconnecting respirators, that result in the deaths of their patients. See Quill, 80 F.3d at 730; *Cruzan*, 497 U.S. at 296-98 (Scalia, J., concurring) (no distinction between action and inaction when both result in death). To deny dying patients the right to choose self-administered prescription drugs as an alternative to assured anguish and degradation, and then to hide this prohibition under the veil of protectionism, is offensive not only to individual autonomy, but also to the will of the American populace, who, as surveys indicate (*see supra*, p. 9) want this choice to be legal.

4. The Availability of Physician-Assisted Suicide Protects The Interests Of Family Members And Loved Ones. -- The states also assert an interest in protecting the family and friends of terminally-ill individuals. The Coalition submits that affirming the lower courts' decisions furthers that interest by ensuring that family members and friends will not be forced to choose between witnessing a loved one suffer a slow and agonizing death, or acting to assist him or her to end the suffering.

The Coalition knows that the family and friends of terminally-ill individuals experience painful feelings of helplessness and guilt at impotently watching a loved one's prolonged suffering. See, e.g., Betty Rollin, *Last Wish*. Thus, these people often empathize with their loved one's desire to hasten death.

While it is impossible to account for the number of suicides by the terminally-ill that have involved the assistance of family members or friends, there is evidence that the practice exists:

Family members, family physicians, friends, and even freelance euthanasis . . . are now assisting in

suicides with no more guidance than their own limited personal experiences and rules. No survey, no poll, no investigation, no educated guesses will ever yield knowledge of the number of people who have died by overdoses, plastic bags, self-inflicted gunshot wounds, or physician-administered lethal drugs -- when they should instead simply have had good counseling and better medical treatment of their pain, shortness of breath, or depression.

Shavelson, *A Chosen Death* at 103. See also Miller et al., 331 New Eng. J. Med. 119. Moreover, such attempts frequently fail -- with tragic consequences for the terminally-ill individual. See, e.g., Clyde H. Farnsworth, *Vancouver AIDS Suicides Botched*, N.Y. Times, June 14, 1994, at C12 (describing academic study which "shows that in the absence of regulation and medical supervision, [assisted-suicide] is occurring in horrific circumstances, like backstreet abortions."); Kolata, N.Y. Times, June 14, 1994 C1 (reporting instances of unsuccessful assisted suicides including story of Illinois man who tried to smother terminally-ill friend with a pillow but instead asphyxiated him just enough to destroy most of his brain's functions).

In addition, prohibiting physician-assisted suicide adversely affects the bereavement process of family members and friends of a terminally-ill patient who chooses to hasten death. Patients seeking to protect their loved ones from potential criminal prosecution are likely to plan and commit suicide without informing them. The secrecy surrounding such a death instills confusion, guilt and uncertainty in the survivors which hampers their grieving process. In addition, where the loved one provides assistance in hastening death, the secrecy is compounded since he or she is unable to talk about the death for fear of adverse legal consequences.

One of the most consistent findings in the clinical bereavement literature is the importance of social support for the survivors. When the mourner perceives that

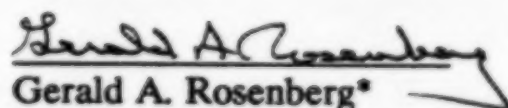
support is not available or that the loss is not socially acceptable or acknowledged, there is an increased risk for complicated mourning. Therese A. Rando, *Treatment of Complicated Mourning*, 495 (Research Press, Champaign, IL 1993). Confiding in others plays a central role in the coping process; behavioral inhibition places cumulative stress on the body and increases the long-term possibility of stress-related disease and psychological damage. J.W. Pennebaker, R.C. O'Herron, *Confiding in Others and Illness Rates Among Spouses of Suicide and Accidental-death Victims*, 93 J. of Abnormal Psych., 473-476 (1984).

Legalization of physician-assisted suicide would provide an environment in which the dying person is not forced to act in secret and one in which family members could be present at the assisted death and discuss it in an open and healthy fashion. Additionally, legalization would enable family members and friends, who wish to honor their loved one's request for help to end his or her intractable suffering to obtain the assistance of experienced physicians. This is clearly preferable to exposing family members and friends to the legal, medical and psychological risks presently associated with assisting a loved one to die.

CONCLUSION

For the foregoing reasons, and for those set forth in the Respondents' briefs, the judgments below should be affirmed.

Respectfully submitted,



Gerald A. Rosenberg*

Frances Kulka Browne

Stacey B. Creem

J. Mark Young

Rosenman & Colin LLP

575 Madison Avenue

New York, NY 10022

(212) 940-8800

*Counsel for Amicus Curiae***

* Counsel of Record

** *Counsel for Amicus Curiae* acknowledge the assistance of Virginia L. Morrison.

APPENDIX

The Coalition's members are representative of every facet of the hospice caregiving team. These palliative care specialists practice in hospices and hospitals throughout the country; serve on ethics committees and policymaking boards; instruct medical students; and are responsible for the operation of individual hospices, hospice systems, specialized clinics, and family medical practices.

The Coalition's members are: Rev. Diane Bagues, hospice chaplain; Robert Bendiksen, Ph. D., professor, University of Wisconsin-LaCrosse, member of Gunderron Lutheran IRB/Human Subjects Subcommittee; Zail Berry, M.D., former medical director of Washington, D.C. Home and Hospice; Robert Brody, M.D., chief, Pain Consultation Clinic and chair, Ethics Committee, San Francisco General Hospital and clinical professor of Medicine, University of California, San Francisco; Michael J. Cassidy, M.D., medical director Hospice Visiting Nurse Association and Hospice of Northern California; Joanna Cooper, M.D., clinician, East Bay Neurology, Berkeley, California; William Curtis, M.D., radiologist, member of Hospice Ethics Committee, member of Boulder County and Colorado Medical Society, emeritus member of American Medical Association; Susan Edenborough, director, Crossroads Home and Hospice, San Francisco; Jonathan Gavrin, M.D., anesthesiologist, internist and palliative care specialist, and a member of the faculty at University of Washington and Fred Hutchinson Cancer Research Center; David Hibbard, M.D., family practitioner, Hospice Ethics Committee member; Sarah Hogenauer, R.N., M.S., coordinator, Hospice Care Network, Westbury, New York; Constance Holden, R.N., M.S.N., clinical nurse specialist, executive director of

Hospice of Boulder County, Colorado, a member of the NHO Ethics Committee and the Colorado Governor's Commission on Life and the Law; Rev. Edward Holland, United Methodist Minister and hospice chaplain; Gary Johanson, M.D., a member of the American Academy of Hospice and Palliative Medicine Ethics Committee; Frank P. Lamendola, R.N., Ph. D. candidate, University of Minnesota, former hospice nurse manager; Eric Loewy, M.D., professor of Medicine, University of California, Davis; Fred Marcus, M.D., oncologist and palliative care specialist, attending physician, Stanford University Hospital, Internal Medicine and Oncology; Larry D. Miller, R.N., former hospice director; Linda Norlander, R.N., B.S.N., hospice administrator, member of Minnesota Hospice Organization Legislative Committee; Ben A. Rich, J.D., Ph. D., assistant professor and assistant director, Program in Health Care Ethics, Humanities and Law, University of Colorado Health Center, and a member of the Ethics Committee of the Hospice of Boulder County, Colorado; Patricia Carson Sussman, director of Hospice for Visiting Nurses' Association and Hospice of Northern California; John Stansell, M.D., medical director of San Francisco General Hospital AIDS Clinic; and Phyllis Taylor, R.N., hospice nurse and educator.